# Healthwatch England – Keogh Report overview for local Healthwatch

As you know Professor Sir Bruce Keogh KBE published his report into the quality of care and treatment provided by 14 trusts with persistently high mortality rates on 16th July 2013.

In order to ensure local Healthwatch are kept informed, we have reviewed the report and pulled out the key points, often directly from the report, for you to consider.

## Sir Bruce's Letter to the Secretary of State

In his letter to the Secretary of State, Sir Bruce sets up why he has been asked to conduct this review. The 14 trusts on which the review is based have been picked because they have been outliers for the last two consecutive years on either the Summary Hospital-Level Mortality Index (SHMI) or the Hospital Standardised Mortality Ratio (HSMR).

He is clear that he wants to diagnose problems with these trusts to help and support them through their recovery and improvement. Although each of the individual trusts have a specific report about their circumstances, pressures and challenges – there were common themes which emerged which could demonstrate learning across the system. These were:-

1) the limited understanding of how important and how simple it can be to genuinely listen to the views of patients and staff and engage them in how to improve services.
2) the capability of hospital boards and leadership to use data to drive quality improvement. This is compounded by how difficult it is to access data which is held in a fragmented way across the system.
3) the complexity of using and interpreting aggregate measures of mortality, including HSMR and SHMI. The fact that the use of these two different measures of mortality to determine which trusts to review generated two completely different lists of outlier trusts illustrates this point.
4) the fact that some hospital trusts are operating in geographical, professional or academic isolation. As we've seen with the 14 trusts, this can lead to difficulties in recruiting enough high quality staff, and an over-reliance on locums and agency staff
5) the lack of value and support being given to frontline clinicians, particularly junior nurses and doctors.
6) the imbalance that exists around the use of transparency for the purpose of accountability and blame rather than support and improvement. Unless there is a change in mind set then the transparency agenda will fail to fulfil its full potential

Sir Bruce thanks the 14 trusts for the openness and honesty with which they took part in the review and reiterated it is not a time for recriminations but for considered debate, a concerted improvement effort and a focus on clear accountability.

## Eight Achievable Ambitions for Quality

The Keogh review has identified eight specific ambitions for improving quality across the NHS in the next two years.

**Ambition 1**

**We will have made demonstrable progress towards reducing avoidable deaths in our hospitals, rather than debating what mortality statistics can and can't tell us about the quality of care hospitals are providing.**

Action

☐ All trusts should rapidly embed the use of an early warning system and have clinically appropriate escalation procedures for deteriorating, high-risk patients - in particular at weekends and out of hours. Commissioners and regulators should seek assurance that such systems are in place.

☐ Professor Nick Black at the London School of Hygiene and Tropical Medicine and Professor Lord Ara Darzi at Imperial College London will conduct a study into the relationship between 'excess mortality rates' and actual 'avoidable deaths'. This will involve conducting retrospective case note reviews on a substantial random sample of in-hospital deaths from trusts with lower than expected, as expected and higher than expected mortality rates.

☐ This study will pave the way for the introduction of a new national indicator on avoidable deaths in hospitals, measured through the introduction of systematic and externally audited case note reviews. This will put our NHS ahead of other health systems in the world in understanding the causes of and reducing avoidable deaths.

**Ambition 2**

**The boards and leadership of provider and commissioning organisations will be confidently and competently using data and other intelligence for the forensic pursuit of quality improvement. They, along with patients and the public, will have rapid access to accurate, insightful and easy to use data about quality at service line level.**

Action

☐ All those who helped pull together the data packs produced for this review must continue this collaboration to produce a common, streamlined and easily accessible data set on quality which can then be used by providers, commissioners, regulators and members of the public in their respective roles. Healthwatch England will play a vital role in ensuring such information is accessible to local Healthwatch so that they and the consumers they serve can build a picture of how their local service providers are performing. The National Quality Board would be well placed to oversee this work.

☐ Boards of provider organisations - executives and non-executives - must take collective responsibility for quality within their organisation and across each and every service line they provide. They should ensure that they have people with the specific expertise to

know what data to look at, and how to scrutinise it and then use it to drive tangible improvements. Over the last decade, many hospitals in the United States have recognised the importance of this by creating board level Chief Quality Officers. Creating a new board role is not essential, but having someone with the breadth of skills required is.

☐ NHS England, the NHS Trust Development Authority and Monitor should work together to streamline efforts to address any skills deficit amongst commissioners, NHS Trusts and NHS Foundation Trusts around the use of quantitative and qualitative data to drive quality improvement.

☐ Sir Bruce Keogh commits to ensuring that the requirements for Quality Accounts for the 2014-15 round begin to provide a more comprehensive and balanced assessment of quality.

**Ambition 3**

**Patients, carers and members of the public will increasingly feel like they are being treated as vital and equal partners in the design and assessment of their local NHS. They should also be confident that their feedback is being listened to and see how this is impacting on their own care and the care of others**.

Action

☐ Realtime patient feedback and comment must become a normal part of provider organisations' customer service and reach well beyond the Friends and Family Test.

☐ Providers should forge strong relationships with local Healthwatch who will be able to help them engage with patients and support their journey to ensuring more comprehensive participation and involvement from patients, carers and the public in their daily business.

☐ The very best consumer-focused organisations, including some NHS trusts, embrace feedback, concerns and complaints from their customers as a powerful source of information for improvement. Patients and the public should have their complaints welcomed. Transparent reporting of issues, lessons and actions arising from complaints is an important step that the NHS can take immediately to demonstrate that it has made the necessary shift in mindset.

☐ Monitor and the NHS Trust Development Authority should consider the support, development and training needed for Non-Executive Directors and Community, Patient and Lay Governors to help them in their role bringing a powerful patient voice to Boards.

☐ All NHS organisations should seek to harness the leadership potential of patients and members of the public as they fulfil their respective responsibilities whether as providers, commissioners or as part of future inspections by the regulators. Patient and public engagement must be central to those who plan, run and regulate hospitals and each has improvements to make in this respect.

**Ambition 4**

**Patients and clinicians will have confidence in the quality assessments made by the Care Quality Commission, not least because they will have been active participants in inspections.**

Action

☐ The new Chief Inspector of Hospitals has agreed to adopt and build on this review methodology as he takes forward the Care Quality Commission's new inspection regime for hospitals.

☐ In the new system, the place that data and soft intelligence comes together is in the recently formed network of Quality Surveillance Groups. These must be nurtured and support the Care Quality Commission in identifying areas of greatest risk.

☐ Provider boards might wish to consider how they themselves could apply aspects of the methodology used for this review to their own organisations to help them in their quest for improved quality.

**Ambition 5**

**No hospital, however big, small or remote, will be an island unto itself. Professional, academic and managerial isolation will be a thing of the past.**

Action

☐ NHS England should ensure that the 14 hospitals covered by this review are incorporated early into the emerging Academic Health Science Networks. We know that the best treatment is delivered by those clinicians who are engaged in research and innovation.

☐ Providers should actively release staff to support improvement across the wider NHS, including future hospital inspections, peer review and education and training activities, including those of the Royal Colleges. Leading hospitals recognise the benefits this will bring to improving quality in their own organisations. Monitor and the NHS Trust Development Authority should consider how they can facilitate this.

**Ambition 6**

**Nurse staffing levels and skill mix will appropriately reflect the caseload and the severity of illness of the patients they are caring for and be transparently reported by trust boards.**

Action

☐ As set out in the Compassion in Practice, Directors of Nursing in NHS organisations should use evidence-based tools to determine appropriate staffing levels for all clinical areas on a shift-by-shift basis. Boards should sign off and publish evidence-based staffing levels at least every six months, providing assurance about the impact on quality of care and patient experience.

☐ The National Quality Board will shortly publish a 'How to' guide on getting staffing right for nursing.

**Ambition 7**

**Junior doctors in specialist training will not just be seen as the clinical leaders of tomorrow, but clinical leaders of today. The NHS will join the best organisations in the world by harnessing the energy and creativity of its 50,000 young doctors.**

Action

☐ Sir Bruce Keogh strongly advises Medical Directors to consider how they might tap into the latent energy of junior doctors, who move between organisations and are potentially our most powerful agents for change. Equally, he would strongly encourage Directors of Nursing to think about how they can harness the loyalty and innovation of student nurses, who move from ward to ward, so they become ambassadors for their hospital and for promoting innovative nursing practice.

☐ Junior doctors must routinely participate in trusts' mortality and morbidity review meetings.

**Ambition 8**

**All NHS organisations will understand the positive impact that happy and engaged staff have on patient outcomes, including mortality rates, and will be making this a key part of their quality improvement strategy.**

Action

☐ All NHS organisations need to be thinking about innovative ways of engaging their staff.

☐ Addressing this issue is part of the action plans for all of the 14 trusts which provides them with an opportunity to lead the way on this.

## Areas for improvement in the 14 trusts

The following key themes were identified in the design of the review as being core foundations of high quality care for patients and each panel investigated as minimum set of key lines of enquiry under each heading.

1. **Patient experience** – Understanding how the views of patients and related patient experience data is used and acted upon (such as how effectively are complaints dealt with and the 'visibility' of feedback themes reviewed at a board level)

- Only United Lincolnshire was an outlier across the majority of patient experience measures.

- "There was a tendency in some of the hospital to view complaints as something to be managed, focusing on the production of a carefully-worded letter responding to the patient's concerns as the main output".

- "The length of time to respond adequately to complaints was also too long in a number of the trusts, as was the simple lack of acknowledgement or apology where care was not provided to the appropriate standard."

- "The review teams would much rather have seen evidence that trusts were actively seeking out and encouraging feedback (low level of complaints should be seen as a source for concern not celebration), trying to investigate and understand it, and then using that insight to make improvements to services (in the way that successful customer-focused organisations do)

**2. Safety** – understanding issues around the Trust's safety record and ability to manage these. The reviews found areas for improvement across all the trusts including:

- processes were generally in place but not fully understood by staff, resulting in patchy implementation;

- inadequate safety and equipment checks at some organisations which required immediate escalation and action by management;

- more work was needed at some Trusts on issues such as infection control and reducing incidents of pressure ulcers;

- poor quality root cause analysis of incidents and limited dissemination of learning from when things go wrong.

All but two trusts had 'never events' which is extremely concerning (never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented) and require significant action in response to this.

One consistent theme throughout almost all of the organisations reviewed was the management of complex deteriorating patients and the monitoring of Early Warning Scores.

**3. Workforce** – understanding issues around the Trust's workforce and its strategy to deal with issues within the workforce (for instance staffing ratios, sickness rates, use of agency staff, appraisal rates and current vacancies) as well as listening to the views of staff

- The initial analysis of the available data indicated that there were various workforce-related problems, including high rates of sickness absence, heavy reliance on agency staff to compensate for large numbers of vacant posts.

- During several of the reviews, staff came forward to tell the review teams about their concerns in confidence. These staff felt unable to share their anxieties about staffing levels and other issues with their senior managers, which suggested that staff engagement at some of the trusts was not good.

- All 14 trusts have recommendations in their action plans relating to workforce issues. They are all undertaking urgent reviews of safe staffing levels. Four trusts are also taking forward actions to improve whistle-blowing policies.

**4. Clinical and operational effectiveness** – understanding issues around the Trust's clinical and operational performance and in particular how Trusts use mortality data to analyse and improve quality of care

- All trusts were functioning at high levels of capacity in the urgent care pathway. This frequently led to challenges in A&E and, as a consequence, cancellations of operations due to bed shortages and difficulty meeting waiting time targets. This, in turn, put pressure on staff and also on the management of patient flows in the rest of the hospital.

- All trusts need to engage more effectively with local health economy partners to improve the urgent care pathway including reviewing options to reduce A&E attendances and ensure efficient and effective discharge into community beds or alternative care arrangements.

**5. Governance and leadership** – understanding the Trust's leadership and governance of quality.

We did not see sufficient evidence to demonstrate that many Board and clinical leaders were effectively driving quality improvement. In a number of trusts the capability of medical directors and/or directors of nursing was questioned by the review teams. Common concerns were:

- poor articulation of the strategy for improving quality;

- many Trusts had findings from quality and safety reviews undertaken recently by internal and external parties but could not show a comprehensive and consistent approach to learning from these;

- a significant disconnect between what the clinical leadership said were the key risks and issues and what was actually happening in wards and departments around the hospitals.

There were also weaknesses in the assurance that Boards were getting over this important area, in part because of the incomplete performance dashboards presented to them and in part because they are not consistently seeking independent assurance. All Trusts need to review their quality performance reporting to ensure it is measuring the right things, triangulated effectively to identify risk areas and is tested through systematic assurance programmes. Some of the significant issues highlighted in the reviews were not on Boards' agenda at all.

They are not probing in the right areas and not listening to staff, patients and stakeholders to gather independent sources of assurance. Only eight of the organisations identified mortality as a top risk to the quality of the care that they provided.

## Other aspects of the report

- The report is clear that overall mortality in hospital has fallen over the last decade and that "*factors that might have been expected – and are frequently claimed – to impact on high mortality, such as access to funding…were not found to be statistically correlated with the results of these trusts*"

- There was a section about the capacity for improvement and requirement for external support which the authors hope will be instructive for other trusts. Points in this section include – a lack of quality governance, trusts existing in isolation and not sharing knowledge or problems, lessons not being learned, financial pressures distracting trusts, capacity for self-improvement is needed from external organisations.

There are 14 individual reports – one for each of the trusts reviews – which specifically set out what the problems have been, what the recommendation is and what the trust response is. These reports are easy to read and do explain the issues clearly. The full reports on the 14 trusts are available HERE [link to 14 reports].